



AGENCY OF HUMAN SERVICES  
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection  
103 South Main Street  
Waterbury, VT 05671-2306  
<http://www.dail.vermont.gov>  
Voice/TTY (802) 871-3317  
To Report Adult Abuse: (800) 564-1612  
Fax (802) 871-3318

July 15, 2015

Ms. Lois Langlois, Manager  
Rivers Edge Community Care Home  
5 Hunt Street  
Bennington, VT 05201

Dear Ms. Langlois:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **July 6, 2015**. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

A handwritten signature in cursive script that reads "Pamela M. Cota".

Pamela M. Cota, RN  
Licensing Chief



Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  0085	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED  R 07/06/2015
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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

RIVERS EDGE COMMUNITY CARE HOME

5 HUNT STREET  
BENNINGTON, VT 05201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{R100}	Initial Comments:  An unannounced on-site second follow-up survey was conducted by the Division of Licensing and Protection on 7/6/15. Citations remain uncorrected as follows.	{R100}		
{R104} SS=8	V. RESIDENT CARE AND HOME SERVICES  5.1 Admission  5.2.a Prior to or at the time of admission, each resident, and the resident's legal representative if any, shall be provided with a written admission agreement which describes the daily, weekly, or monthly rate to be charged, a description of the services that are covered in the rate, and all other applicable financial issues, including an explanation of the home's policy regarding discharge or transfer when a resident's financial status changes from privately paying to paying with SSI or ACCS benefits. This admission agreement shall specify at least how the following services will be provided, and what additional charges there will be, if any: all personal care services; nursing services; medication management; laundry; transportation; toiletries; and any additional services provided under ACCS or a Medicaid Waiver program. If applicable, the agreement must specify the amount and purpose of any deposit. This agreement must also specify the resident's transfer and discharge rights, including provisions for refunds, and must include a description of the home's personal needs allowance policy.  (1) In addition to general resident agreement requirements, agreements for all ACCS participants shall include: the ACCS services, the specific room and board rate,	{R104}		

Division of Licensing and Protection  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

8888

VMIE13

If continuation sheet 1 of 3

R104 + R181 POC accepted 7/13/15 BBurke RN/AME

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  0085	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED  R 07/06/2015
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NAME OF PROVIDER OR SUPPLIER  
**RIVERS EDGE COMMUNITY CARE HOME**

STREET ADDRESS, CITY, STATE, ZIP CODE  
**5 HUNT STREET  
BENNINGTON, VT 05201**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{R104}	Continued From page 1  the amount of personal needs allowance and the provider's agreement to accept room and board and Medicaid as sole payment.  This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to insure that 10 of 24 residents, #1, #2, #3, #4, #5, #6, #7, #8, #9 and #10, had signed admission agreements that described the daily, weekly or monthly rate to be charged. Findings include:  Upon arrival at facility, a request was made for admission agreements for all residents, as the admission agreements are currently not kept in the resident's medical record. Based on the current census of 24, there were 3 out of 4 recent admissions Resident #1, #2 and #3, and 7 out of 20 residents that were in the facility at the time of the 5/4/15 survey, Resident #4, #5, #6, #7, #8, #9 and #10, that did not have rates listed. Interview with the office staff personnel at 10:55 AM, the facility had not completed the admission agreements. Per interview and confirmation with the Registered Nurse at 11:05 AM, the rates had not been filled in on the admission agreements of these 10 residents.	{R104}	<i>ALL RESIDENT ADMISSION AGREEMENTS WERE COMPLETED DURING ON-SITE SURVEY WITH OWNER. RATES WILL BE FILLED IN AT TIME OF ADMISSION BY RN.</i>	
{R181} SS=E	V. RESIDENT CARE AND HOME SERVICES  5.11 Staff Services  5.11.d The licensee shall not have on staff a person who has had a charge of abuse, neglect or exploitation substantiated against him or her, as defined in 33 V.S.A. Chapters 49 and 69, or	{R181}		<i>MWH/TE 7/10/15</i>

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  0085	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  R 07/06/2015
NAME OF PROVIDER OR SUPPLIER  RIVERS EDGE COMMUNITY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 5 HUNT STREET BENNINGTON, VT 05201		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{R181}	Continued From page 2  one who has been convicted of an offense for actions related to bodily injury, theft or misuse of funds or property, or other crimes inimical to the public welfare, in any jurisdiction whether within or outside of the State of Vermont. This provision shall apply to the manager of the home as well, regardless of whether the manager is the licensee or not. The licensee shall take all reasonable steps to comply with this requirement, including, but not limited to, obtaining and checking personal and work references and contacting the Division of Licensing and Protection in accordance with 33 V.S.A. §6911 to see if prospective employees are on the abuse registry or have a record of convictions.  This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to insure to have on file the required child abuse and adult abuse registry checks on 3 of 3 staff recently hired. Finding include:  Based on staff interview and record review, the facility failed to have records of the Vermont State Child and Adult Registry checks on 3 employees that have been hired since 5/4/15. Employee #1 was hired 5/4/15, #2 was hired 6/10/15 and #3 was hired 6/26/15. Records indicate that a request for the Child and Adult Registry checks be completed, but there is no evidence of the State Agencies replying to the request. The business staff stated that they did not know how to do the on-line registry checks and had not followed up regarding the checks. At 11:30 AM the business office staff confirmed that these employees have been working on schedule since date of hire without completion of the required background checks.	{R181}	BUSINESS STAFF WILL COMPLETE ALL REQUIRED ABUSE CHECKS PRIOR TO STAFF WORKING, CURRENT EMPLOYEES WILL BE COMPLETED BY 7/14/2015  MUNTER 7/10/15	